Testimony for the

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on

"Ways to Reduce the Cost of Health Insurance for Employers, Employees and their Families,"

Submitted by

Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters
2000 North 14th Street
Suite 450
Arlington, VA 22201
(703) 276-0220
(703) 841-7797 FAX
jtrautwein@nahu.org
www.nahu.org

National Association of Health Underwriters

America's Benefits Specialists

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Good morning. My name is Janet Trautwein, and I am the CEO of the National Association of Health Underwriters (NAHU). NAHU is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 20,000 employee benefit specialists nationally. Our members oversee the health insurance plans of millions of Americans and work on a daily basis to help employers purchase, design and implement health plans for their employees. We appreciate the opportunity to be here today to share our thoughts on ways to make health insurance coverage more affordable for both employers and their employees.

We believe all Americans deserve a health care system that delivers both world-class medical care and financial security. Americans deserve a system that is responsible, accessible and affordable. This system should boost the health of our people and should improve rather than drain our country's economy.

NAHU believes that any reform proposal should build on the strengths of our current system, which centers on employer-sponsored coverage. Our support for the employer-based system is well-founded, as this system efficiently combines key elements that make health care accessible to individuals and families all over America by providing the financing to pay for health care services.

Benefits of Employer-Sponsored Coverage

The federal government supports employer-sponsored coverage through the Tax Code by recognizing health insurance premiums paid by employers on behalf of their workers as a business cost, which are generally deductible by the employer for tax purposes. These same premium payments by employers are currently not taxable to employees as a part of their compensation. NAHU believes the preservation of this current federal employer deduction and employee exclusion is critical to the success of any health reform effort.

For working individuals, there are a multitude of advantages to employer-sponsored coverage, not the least of which is the significant contribution most employers make toward the cost of coverage for employees and their dependents. The average employee receives an 84 percent subsidy from his employer toward the cost of coverage, regardless of income. This subsidy—on average—has remained constant over time even though health care costs have increased substantially. This high level of subsidy results in a very high "take up" of coverage by employees. Without the funding provided through employers, many people who have coverage today would be uninsured.

Employers provide coverage to their employees for an important business reason: to attract and retain the best employees. Even the smallest of employers that struggle with the cost of coverage want to be able to distinguish themselves from their competitors by being known as a great place to work with comprehensive benefits. When designing health care solutions, we need to make sure we preserve the employer's connection to their plan and the funding that goes along with it for their employees.

For larger employers, group purchasing power helps them obtain preferential pricing and enables them to provide benefits that are generally more extensive than what is available to consumers spending a similar amount in the individual market. Administrative costs are also lower than in the individual market because coverage is provided to many individuals through a single transaction with one employer.

With any size of employer plan, controlled entry into the plan at the time of hire ensures that those entering employer sponsored plans are doing so as a result of their employment rather than as a result of their believing they need to seek health insurance coverage. For this reason, risk is spread more efficiently and effectively with less adverse selection than in the individual market. The ease of group purchasing and enrollment, combined with the reliable payment of group coverage, results in many more insured persons than if they were required to obtain coverage on their own.

Employer-based health insurance is also more flexible than government-run public insurance programs such as Medicare, as it allows benefits to be customized to the specific employer groups. Even a small employer has many choices in plan design. Driven by their bottom line and utilizing a relatively streamlined management system, employers strive to obtain the best coverage at the lowest cost to meet their goal of hiring and retaining the best possible workers. Employer flexibility allows their plans to be modified over time to take advantage of current cost and quality considerations and to meet the specific needs of their group of workers. Employers also have the capability to pick and choose among new benefit, payment and organization innovations, and can implement new programs and halt unsuccessful ones relatively quickly. In contrast, public programs are less likely to be able to meet the precise needs and wants of their entire constituency, and response to innovations and changes in the insured population's needs is likely to be slower because of the political and regulatory process.

Regarding a government-run public plan option, there are many stakeholders in the health care reform debate that have articulated the belief that such a plan is necessary in the marketplace and should be offered as an alternative to traditional private-market, employer-sponsored and individual health insurance coverage. NAHU feels that, when crafting comprehensive health reform legislation, Congress needs to avoid creating a public health plan option to be offered as an alternative to, or in competition with, private-market health plan offerings.

NAHU has many concerns about a public health coverage program buy-in option that competes with the private insurance market. Chief among them is the potential for an unlevel playing field between the two coverage options. Even if extreme care was taken

to ensure that factors such as subsidies, rating and issuance requirements were the same relative to the public and private plan options, the two options could never truly be equal.

It will cause significant problems if the rules that apply to public plan coverage differ from those that apply to private insurance markets. Bad products will drive out good ones. If a level playing field between public and private cannot be established and sustained, it could deprive patients and providers of access and appropriate incentives and payment mechanisms to achieve the best value for health care dollars.

The creation of a government-run public plan insurance program also would likely complicate and make more difficult the most efficient pooling of risk among private insurance carriers, especially in employer-based coverage. Current natural groups relating to geography or age would likely become fragmented and discrete, thereby diminishing the advantages and efficiencies of group purchasing.

As but one possible scenario, to the degree that younger and healthier people enroll in a government-run public plan, the "remaining" employer-based market could become a less healthy mix of insurable risk, as sicker, older workers stay with their employer-based coverage while more of the healthier workers move to a public plan. And the exodus of younger and healthier populations from an employer's pool would likely drive up the costs of the employer plan, for both the employer and beneficiary alike. The likely destabilization of group risk pools that could well result raises the question of whether employers would continue to offer health insurance to their workforce.

Another key issue is the cost impact a public plan option will have on all Americans, particularly in this economic climate. If Congress creates a public health plan option for the under-65 population, privately insured people will be forced to bear significant indirect costs due to its existence because of cost-shifting, or the "hidden tax" imposed when providers of medical care adjust the prices they charge to private insurance companies in order to offset losses from partial or non-payers. These losses are primarily attributable to uncompensated care costs and declining reimbursements from Medicare and Medicaid, and they have a significant impact on private health insurance premiums. A recent Milliman report estimated that annual health care spending for an average family of four is $1,788 higher than it would be if Medicare, Medicaid and private employers paid hospitals and physicians similar rates, with total provider reimbursement unchanged.

The ideal solution for this would require that providers be reimbursed at the same level they are commercially for all public plans. Given the changing nature of commercial provider contracts, this may not be possible for public programs, but efforts to equalize payments would go a long way toward resolving the payment disparity and would provide significantly greater payment and premium stability for providers and employers and their employees.

NAHU's final concern regarding a new government-run public plan option is such a plan's long-term fiscal and actuarial sustainability, which is already a significant issue with the federal Medicare program. From the 2008 Trustees' Report, Medicare's

liabilities are expected to exceed revenue dedicated to paying for the program by $36 trillion over the next 75 years, and the trust fund that pays for hospital services is expected to go bankrupt in 2019. Total Medicare spending is projected to more than triple as a share of the national economy, rising from 3.2 percent of GDP in 2007 to 6.3 percent in 2030, 8.4 percent in 2050, and 10.7 percent in 2080. Federal individual income tax collections amount to only about 8.5 percent of GDP. Covering just the increase in Medicare spending expected by 2030 would require a 36-percent, across-the-board individual income tax hike.

By contrast, there are very few industries in the United States that are as heavily regulated as private health insurance markets. Private health insurance markets are subject to stringent actuarial and solvency standards, standards that a government-run public plan option is unlikely to be held against, if the experiences of Medicare and Medicaid are any lesson. This is not to say that health insurance markets cannot be improved upon through government reforms to enhance access, affordability and consumer rights but, whether through the federal government or state governments, there are myriad laws and regulations that address a range of standards and requirements that currently oversee health plans and health insurance.

Cost Containment

NAHU applauds government leaders and others who have put forward comprehensive reform proposals, even when we disagree with their proposed solutions. There is no doubt that changes are needed, but changes must begin by addressing the true underlying problem with our existing system: the cost of medical care. The reality is that consumers pay for all health care costs in one of three ways: through taxes, health insurance premiums or out-of-pocket expenditures. If the cost of health care becomes too great, the method of payment no longer matters – the country and its people will be bankrupt and/or unable to access care.

Constraining skyrocketing medical costs is the most critical – and vexing – aspect of health care reform. It is the key driver in rising health insurance premiums and it is putting the cost of health care coverage beyond the reach of many Americans. There is no one magic answer to health care cost containment and there are many reasons health care costs are skyrocketing. Addressing this massive societal problem requires a multitude of comprehensive actions by individual citizens and elected officials.

However, NAHU has identified some key health care cost containment mechanisms that should be included in any national comprehensive reform effort. First among them is wellness promotion. Unhealthy behavior and lifestyle choices are two key factors in the increased cost of health care. Research shows that behavior is the most significant determinant of health status,[1] with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity. Furthermore, the Centers for Disease Control and Prevention estimates that 75 cents of each U.S. health care dollar is spent on treatments for patients with one or more chronic condition (such as

[1] Mercer Management Journal 18; Centers for Disease Control and Prevention.

heart disease, asthma, cancer or diabetes). These diseases are often preventable, and frequently manageable through early detection, improved diet, exercise and treatment therapy.

We believe that the first step by government should be by example, and that all federal and state governments should be required to incorporate wellness and disease-management programs into medical programs for employees and government-subsidized health coverage programs such as Medicaid, Medicare, CHIP and the Veterans Health System. Standards for the most effective programs have been developed by URAC, and would provide benchmarks for best practices in this area. We also believe that private employers should be provided with legal protection, tax incentives and premium incentives for implementing smoking, drug, alcohol and other wellness programs to encourage their employees and their families to adopt healthier lifestyles.

A second effort toward cost containment would be to identify ways to avoid duplication of procedures and overuse of high-end procedures in situations where they add little value. Both patients and the provider community should focus on identifying less expensive but equally efficacious alternatives. In addition, preventable mistakes by providers of medical care not only drive up health care costs, but also cost lives.

We believe incentives should be provided for doctors and medical facilities to improve system efficiencies and eliminate errors with pay for performance, best-practice guidelines and support for evidence-based medicine. And although we are greatly encouraged by the funds included in the stimulus bill for creation of electronic medical records, they will be of little use unless standards for interoperability are created to unify the health care system, reduce errors and duplicative procedures, and improve patient satisfaction.

Access for All

Although we are strong supporters of employer-sponsored coverage, it is important to include solutions to help those accessing health insurance through the individual health insurance market too. Controlling cost in this market is more difficult than in an employer-sponsored plan, not because of an inability to pool like policies together – all insurers pool their individual market business – but rather because individuals may voluntarily enter the system whenever they want to, and because they pay for coverage on their own, with after-tax dollars and with no employer contribution. For this reason, the market is prone to a phenomenon known as "adverse selection." Adverse selection occurs when a person delays buying an insurance product until he or she anticipates an immediate need for the benefit. Since individuals always know more about their own health status than anyone else does, and because all of the cost of buying individual health coverage is borne by the insured, the amount of adverse selection occurring in the individual market is very high. This has a direct impact on the pricing of individual-market policies and is the reason why most states today use medical underwriting for individual health insurance coverage.

From a pure access perspective, it would seem that one of the simplest ways to get individual-market buyers covered would be to require that all individual health insurance policies be issued on a guaranteed-issue basis without regard to pre-existing medical history. However, in addition to being accessible to all Americans, individual coverage also must be affordable. As you are aware, America's Health Insurance Plans and the Blue Cross Blue Shield Association have recently announced that they would be able to guarantee-issue coverage in the individual health insurance market and rate without regard to pre-existing conditions IF everyone is required to carry coverage. It is important to note that this is distinctly different from our voluntary system today. If such a purchase mandate is passed, enforcement will take time to become effective. Without near-universal participation, a guaranteed-issue requirement in this market would have the perverse effect of encouraging individuals to forgo buying coverage until they are sick or require sudden and significant medical care. It is very important that some type of financial backstop or risk adjuster be used to ensure that the result of market reform is not the exorbitant premiums we currently see in states that already require guaranteed issue of individual policies but do not require universal coverage or have a financial backstop in place.

As we look at premium stability and the demonstrated importance of an adequate risk-adjustment mechanism, one good model to look at for both the individual and small-employer market is New York with its *Healthy New York* program. Small employers, sole proprietors and uninsured working individuals, regardless of health status, who meet set eligibility criteria and participation rules can purchase a limited range of comprehensive coverage options offered through private carriers and backstopped with a state-level reinsurance pool for extraordinary claims. Although New York is a guaranteed-issue state for all markets, it still uses this mechanism to spread the risk of higher-risk participants. If we compare the rates for similar coverage in neighboring New Jersey, which is also a guaranteed-issue state but with no financial backstop, it becomes clear that, although premiums are higher in New York than in non-guaranteed-issue states due to community rating laws, the financial backstop provided by the reinsurance mechanism has improved affordability there.

Portability of Coverage – Pre-existing Condition Clauses

Many people interchange the terms "health status or medical underwriting" with "pre-existing condition clauses." These are two distinct insurance terms and need to be discussed separately.

Underwriting based on health status or medical history has to do with how initial health insurance premium rates are determined. In most states, insurers are able to consider a person's health status, along with other important factors, when determining initial rates in the individual and small-group markets. In the individual market, the personal health history of the individual or family applying for coverage is one of the factors used; in the case of small-employer groups, the overall health of the group is considered. In larger groups, where risk is spread more broadly, actual claims experience is used as the primary rate determinant. After the initial premium rate is determined in the individual and small-group markets, then the individuals or small groups are pooled internally by

their health insurance carrier, and subsequent rate increases are based on the overall claims experience of the internal pool.

A pre-existing conditions clause applies to coverage already in force and limits the amount of time a particular condition may be excluded from coverage. Pre-existing condition clauses are used to prevent the adverse selection caused by people from failing to obtain coverage until they know they need the benefit.

Pre-existing condition clauses are rarely a problem for those with employer-sponsored coverage because the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established uniform rules in this area for the group market. Carriers can look back at a new group member's medical history for no more than the six months prior to when the individual joined the group and may exclude coverage for certain conditions for up to 12 months. However, the law rewards those who have consistently maintained health insurance coverage. As long as a new group member has no more than a 63-day break in coverage, the group health plan must give the individual credit for their prior coverage. This credit for prior coverage, as well as the controlled entry and exit into group plans, means that preexisting condition clauses rarely need to be exercised in the group market. They only come into play to prevent true adverse selection, and their timeframe is limited and relatively consistent across the states.

In the individual market, though, there are no consistent rules. Right now, state exclusionary and look-back periods for pre-existing conditions in the individual market range from none at all to five years. NAHU believes greater standardization could easily be achieved in a similar way as was done relative to the small-group market in HIPAA when a federal maximum look-back window of six months and a 12-month exclusionary period was established for the states. Having a pre-existing conditions rule that is consistent in both the individual and group model would also be much simpler for consumers to understand.

Additionally, there is no protection for individuals who want to change carriers or health insurance products within the individual market. A simple way to change this would be to allow consumers credit against any pre-existing conditions limits for prior individual coverage when changing insurance plans, if there is no greater than a 63-day break in coverage, just as is required in the group market by HIPAA. In the absence of a fully implemented and enforceable individual purchase mandate, plans and high-risk options must be able to look back at a new applicant's medical history and impose reasonable waiting periods in order to mitigate adverse selection. Until implementation is complete, greater standardization of limitations is necessary and warranted.

Another inconsistency among both individual and small-group state individual health insurance markets is the way that premium rates are determined at the time of application. Most states allow for the use of medical history or health status as an underwriting factor, as I just discussed. In a few states, the laws require that rates be the same for everyone regardless of gender, age, health status or geographic location (community rating). In a number of others, rating factors are determined by the state but

are limited in nature (i.e., age, gender, industry, wellness, etc.), which is known as modified community rating. However, even in states with modified community rating, the rating factors and how they may be applied vary significantly by state. It is NAHU's view that state individual health insurance markets would benefit from greater standardization as to how premium rates are determined.

The federal government could require that all states meet a minimum standard of rate stabilization by requiring modified community rating instead of health status rating. However, this would need to be undertaken slowly in order to protect against extreme rate shock to some populations, especially younger individuals. Additionally, it is extremely important that wide adjustments be allowed for non-health measures. At a minimum, variations need to be allowed for applicant age of at least five to one (meaning that the rate of the oldest applicant may be no more than five times the rate of the youngest applicant). In addition to age, variations in premium rates should be allowed for other factors such as wellness plan participation, smoking status, industry, family composition and geography.

Finally, the federal government should also make improvements to existing law to make health insurance coverage more portable for people who leave their jobs and employer-based coverage and need to buy coverage in the individual market. Examples of such individuals include early retirees or people who are starting a small business or freelancing, perhaps because they are having trouble finding other work with employer-based coverage. HIPAA attempts to provide individuals who are leaving group health insurance coverage with portability protections to make it easier for them to purchase coverage in the individual market. Unfortunately, the protections are confusing and many consumers unintentionally invalidate their HIPAA guaranteed-issue rights without realizing it, and then risk being denied coverage when they apply for individual coverage.

Under current law, individuals who are leaving group coverage must exhaust either COBRA continuation coverage or any state-mandated continuation-of-coverage option if COBRA is not applicable, before they have any group-to-individual portability rights under HIPAA. Once the consumer exhausts these options, if available, then he or she can purchase certain types of individual coverage on a guaranteed-issue basis, provided that there is no more than a 63-day break in coverage.

Most people who leave group coverage are unaware of all of the stipulations required to receive federal portability-of-coverage protections. Faced with high COBRA or state-continuation premiums, many individuals decline such coverage initially or after a few months. Then, depending on their health status or a family member's, they may experience extreme difficulty obtaining individual-market coverage. To solve this problem, the HIPAA requirement to exhaust state continuation coverage or COBRA before federal guarantees are available should be rescinded, and individuals leaving group coverage should be able to exercise their federal group-to-individual portability rights immediately, provided that there is no more than a 63-day break in coverage.

Subsidies

Some changes need to be made in our tax system simply to provide equity for individual market consumers with their counterparts in employer-sponsored plans. For example, removing the 7.5 percent of adjusted gross limit of medical expenses on tax filers' itemized deduction Schedule A form and allowing the deduction of individual insurance premiums as a medical expense in itemized deductions would help many people who are part-time workers or who work for employers that don't offer health insurance coverage. And to put self-employed individuals who are sole proprietors or who have Sub-S corporations on a level playing field with businesses organized as "C" corporations, their current deduction from gross income should be changed to a full deductible business expense on Schedule C.

NAHU also supports targeted premium-assistance programs for low-income individuals purchasing private coverage, and we feel that the federal government should help finance such programs. A subsidy program could be national in scope, or each state could be required to create one that suits the unique needs of its citizens in partnership with the federal government. Several states have already created successful subsidy programs and their existing structures could be used as a model framework for a national reform. I have included a link to a chart that itemizes some of the state subsidy programs that provide us with some good models and creative ways to help both employers and their employees with the cost of health insurance coverage. Two states in particular should be looked to as models:

Oregon

The Oregon Family Health Insurance Assistance Program (FHIAP)[2] is one state program that could serve as a model. FHIAP is an innovative state coverage initiative that subsidizes both employer-sponsored coverage and individual insurance coverage. Eligible families making over 150% of the Federal Poverty Level who do not receive cash assistance must participate if employer coverage is available, and others can participate on a voluntary basis. Licensed health insurance professionals help employers and individuals with enrollment and participation. The program subsidizes coverage on a sliding scale according to income. Subsidies range from 50% to 95% of the premium. Individuals and families use FHIAP subsidies to pay for insurance at work or to buy individual health plans if insurance is not available through an employer. FHIAP members pay part of the premium. They also pay other costs of private health insurance, such as co-payments and deductibles. Once approved for FHIAP, members are eligible to remain in the program for 12 months. Three to four months before the member's eligibility ends, FHIAP sends a new application and members may re-apply. FHIAP provides direct premium assistance through the insurer for people who use its benefits to purchase individual coverage. For those with employer coverage, FHIAP reimburses employees for the cost of their premium within four days of receipt of a valid pay stub denoting the employee contribution. This program has been around for a number of years and struggles each year with funding, but many have benefited from it and it is a streamlined approach with little administrative cost.

[2] http://www.oregon.gov/OPHP/FHIAP/

Oklahoma
Oklahoma's Employer/Employee Partnership for Insurance Coverage (OEPIC or Insure Oklahoma)[3] is another very successful state subsidy program that works with both employer-sponsored and individual health insurance coverage for self-employed people, certain unemployed individuals and working individuals who do not have access to small-group health coverage. In 2008, 9,923 employees and dependents were directly subsidized by Insure Oklahoma, which is a 234% increase from the previous year.[4] Licensed insurance agents and brokers help identify applicable participants and enroll people and employers in the plan. Through the program, the employer pays only 25% of the premium of the low-wage worker, the employee pays up to 15% of the premium, and the state pays the remainder. The program's passage was supported by insurers, small employers, agents and brokers, and providers. It is funded by a state tobacco tax and federal funds based on a Medicaid Health Insurance Flexibility and Accountability waiver. Twenty insurers participate, offering dozens of qualified products that meet simple specified coverage standards.

Connectors and Exchanges

In 2006, Massachusetts policymakers enacted a far-reaching health reform plan, creating what is known as the Massachusetts health insurance "connector," along with other reforms all designed to improve health insurance coverage affordability and accessibility. Now many policymakers, both in Congress and in other states, are exploring whether the connector concept, which is also sometimes referred to as an exchange or portal or one-stop-shop among other terms, is an effective means of reducing the number of uninsured Americans.

NAHU has thoroughly evaluated the policy ideas behind health insurance connector proposals. We recognize that some believe the connector concept has promise. But NAHU believes Congress needs to carefully weigh the pros and cons of any connector or exchange proposal concerning access to health insurance.

An important point to remember is that the Massachusetts connector is a form of purchasing pool. While purchasing pools may provide more health plan options for individuals to choose from, history shows that they do not reduce health insurance costs. The most successful state purchasing cooperative was operational in California for 13 years, and the costs for small businesses always exceeded what was available in the traditional private market. This pool, the Health Insurance Plan of California (HIPC), closed its doors on December 31, 2006, because it was not financially viable. NAHU is concerned that if a national connector or Exchange is established in such a way that does not allow for a competitive market outside of the connector, a situation could develop that could endanger the ability of individuals and employers to find health care financing in the future.

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[3] http://www.oepic.ok.gov/
[4] Blue Cross Blue Shield Association. "Insure Oklahoma: Overview and Impact." http://www.bcbs.com/issues/uninsured/background/insure-oklahoma-overview.html

In many ways, a connector operates like the Federal Employees Health Benefit Plan, in which many private insurance plans compete to provide coverage for federal workers. But, unlike the FEHBP, a connector does not achieve the marketing and other advantages of a homogenous group. All health insurance products sold through a connector are individual policies, even if they are purchased by an employer in lieu of traditional group insurance coverage. Employers purchasing coverage through a connector may be required to establish premium-only Section 125 "cafeteria" policies through which the connector policies would be purchased. In Massachusetts, the connector replaces the individual insurance market and is a means for qualified individuals to enroll in a state-subsidized health insurance option known as Commonwealth Care. Due to legal obstacles, the Massachusetts connector was only recently able to begin marketing policies to small-employer groups, three years after the Connector was created.

Since the creation of the Massachusetts connector, connector or exchange bills have been introduced in more than 30 state legislatures and the U.S. Congress, as well as many think tanks and foundations, some of whom are represented today at this hearing. Some proponents of a connector believe that our nation's health coverage system should evolve from a primarily employer-based insurance system to an individually based one. A connector would partly achieve this goal and could potentially expand individual employee health insurance options, but it could also cause employees who have traditional group coverage now to lose important benefits.

Proponents say that connectors are government-managed markets that sell individual private and portable health insurance while preserving market forces and fostering competition. Furthermore, it has been argued that pooling a group of individual policies within the connector can mitigate some risk and stabilize premiums. NAHU is not convinced these arguments are true.

There are several reasons why past large-scale health insurance purchasing cooperatives have failed, including adverse selection and an inability to reduce administrative costs. Risk adjustment has been a particular problem. The fact is that when an individual in an employer group can select the coverage that will benefit his or her specific situation the most, they will do exactly that. This usually results in the sickest employees choosing the most flexible coverage that will allow them the greatest degree of provider selection and treatment options. After a while, this pool coverage option is selected so often by sick people that it can not sustain the financial losses and is forced to leave the pool to offer coverage outside the pool environment in a situation where it's more likely to get a variety of risks.

Purchasing cooperatives also have failed to yield significantly lower administrative costs for employers, employees and insurers, and the same will likely hold true for connectors. It is often argued that many individuals and small businesses purchasing coverage together will be able to translate their bulk purchasing power into discounts normally achieved by large businesses. However, many diverse individuals buying insurance together do not have the same rating and risk profile as one large and generally more

homogenous employer group, even if one were to merge individual and small-group markets.

In addition, the cost savings associated with large-employer coverage primarily comes from the fact that the enrollees work for the same employer and have a standardized point of contact. A connector would have to individually address the needs of many subscribers separately. Finally, a connector with 5,000 participating individuals isn't really a pool of 5,000. If there are 10 plan choices with 500 people selecting each choice, what you really have are 10 500-person groups insured by different carriers, not one group of 5,000. As a William M. Mercer study on health insurance purchasing cooperatives commissioned by the Commonwealth of Virginia concluded:

> *"The historical success of HIPCs has been disappointing in general. The enrollments have never reached the expected levels required to enable the HIPCs to be significant negotiators in the market and the hoped-for cost savings have not materialized."*[5]

Potential Conflicts with ERISA, HIPAA and COBRA

NAHU has serious legal concerns about connectors, particularly with regard to situations in which employers would be purchasing or sponsoring individual coverage for employees. Depending on a connector's structure, we see potential conflicts with a number of federal laws, including ERISA, COBRA and HIPAA. These laws serve essential functions to protect consumers, and NAHU does not want to see these protections diminished.

Many connector proposals would require participating employers to create Section 125 cafeteria plans and mandate coverage of certain benefits and employer contributions. This could trigger potential ERISA challenges. These administrative burdens would add to health insurance administrative costs with little, if any, value to consumers or employers. Potential conflicts with HIPAA and COBRA are also of great concern to NAHU. In Massachusetts, all policies sold through the connector are individual policies even if they are offered through an employer. This raises important COBRA and HIPAA questions for employees of companies that previously offered traditional group health insurance coverage but are now offering such coverage through a connector. For example:

- Do employees forfeit their COBRA rights?
- If not, when is COBRA eligibility triggered—upon termination of employment or at the time of the employer group enrollment in the connector individual policy?
- When would group-to-individual portability guaranteed-issue rights under HIPAA be triggered?

These eligibility concerns will likely need to be addressed by Congress if a national connector is created, or it may become a matter for the federal courts. And the potential

[5] Mercer, William M. *Review of Health Insurance Purchasing Cooperatives (HIPCs).* Private study Commissioned by the Commonwealth of Virginia. September 15, 1999.

for such courts limiting existing rights of group health insurance consumers is significant and worrisome.

HIPAA group health provisions also appear to be problematic for connector proposals. HIPAA requires that health plans that involve an employer must comply with all of the group health insurance protections the law mandates. Connector plans sold through employer groups would seem to clearly fall under the category of employer involvement, particularly if employer contributions or the creation of a Section 125 plan were involved. Therefore, Congress would need to clarify that individual health insurance policies purchased by employees with no premium financed by the employer are not the same as group health insurance policies and are not subject to the group insurance requirements specified in HIPAA or ERISA.

Finally, and most important, NAHU feels that connector proposals would do nothing to address the rapidly rising costs of providing medical care in this country, which is the true source of high health insurance premiums. Health insurance market reform measures, no matter how they are structured, do little to reduce costs. In fact, overall state health program costs in Massachusetts have increased by 42 percent since the enactment of the 2006 reforms. The cost of medical care is the key driver in rising health insurance premiums. It is what's putting the cost of health care coverage beyond the reach of many Americans.

Structuring of a Connector or Exchange

Despite all of our concerns about a traditional health insurance exchange, NAHU does recognize the need for greater opportunities to enroll individuals in health insurance coverage. In particular, the issue of individuals who are eligible for programs like Medicaid and CHIP but are not actually enrolling in the coverage needs to be addressed. There is also the perception that uninsured individuals need a centralized place to access coverage option, connect with qualified professionals and make choices based on their individual needs and budgets. Finally, the employer-sponsored health insurance system provides tax advantages but it's not always an available option for everyone.

If Congress does decide to create a national connector or exchange, it is critical that such an entity be structured in such a way that it does not damage or eliminate the traditional private insurance marketplace. If pools totally replace other private-market options, there may be no other vehicle for coverage if the pool fails. One of the most key structural decisions that will need to be made is if a national connector will be a "portal" or a bricks-and-mortar institution and regulatory body that also sells private coverage or offers a public program option. The flea-market approach may be the best way to provide consumers with easier access to coverage options without disrupting the existing private insurance market.

The Internet-based travel company Travelocity is an example of a flea-market approach to access to a service: Private companies compete and sell their products in one place. Travelocity does not regulate the routes airlines fly, nor does it regulate the prices that vendors charge consumers.

Another structural issue Congress will need to address is how a national connector or exchange will mesh with existing and varying state coverage rules and consumer protections. Plan rating rules and other requirements should mirror state laws outside the connector, otherwise adverse selection will be rampant. National experience with purchasing pools of all kinds shows that pools that operate at the state level that also fairly compete with plans outside the pool are the least disruptive to the market. Under no circumstances should rating laws be less restrictive inside the connector, and rating laws more restrictive than the outside market will cause selection against the connector. Also, in terms of rating requirements, Congress should keep in mind that current state rating law differences reveal that more restrictive age bands result in higher costs and lower participation over time.

Greater stability will also be realized by not mixing market types (i.e., not combining individuals purchasing coverage independently with small businesses or other group coverage). State laws differ significantly between the group and individual markets and, actuarially, these segments are quite different. Combining them would cause adverse selection to the pool. And although including the self-employed in a connector is an attractive idea, it should be done cautiously as it can cause the same problems as combining individual and small-employer markets. If both small groups and the self-employed are eligible for participation, extra restrictions should be made on the self-employed to control entry into the pool and to ensure the existence of a business.

One function of the Massachusetts connector is to administer the state's subsidized coverage program, Commonwealth Care. If a national connector is utilized as a means of subsidy administration, such subsidies should be broad-based and available to eligible individuals and businesses both inside and outside the connector. If subsidies are available only inside the connector, crowd-out from existing private plan coverage will be dramatic and could destabilize the market. Subsidies only available in the pool can also result in higher-than-expected costs for those in the pool and an apparent larger number of uninsured than actually exist.

Employer Mandates

Although we are strong proponents of employer-sponsored coverage, a mandate to force employers to provide health insurance to their employees, while well-intentioned, could actually hurt American workers and health insurance coverage by decreasing jobs and economic growth, as well as do little to reach the current uninsured population. It would have a negative impact on wages and job creation, and would principally impact low-skilled employees because employers would be forced to cut jobs to control skyrocketing labor costs.

Measures that would force an employer to spend certain dollar amounts or percentages of their payroll on a health plan that may bear little resemblance to what is needed by a particular employee population merely provide a disincentive for responsible spending and health insurance rate containment.

Additionally, such proposals often come with an opportunity for employers to "opt out" of providing coverage themselves and instead pay into a government-sponsored plan or fund that would provide coverage in lieu of the employer's plan. Such programs would compete unfairly with the private market and cause employers that continue to provide coverage to experience higher costs due to cost-shifting. In a similar vein, proposals that allow employees to opt out of their employer-sponsored plans in favor of some type of pooled purchasing arrangement would jeopardize the ability of employers to continue to offer their plans by decreasing pooling efficiencies, increasing employer administrative cost for tracking plan selection, and jeopardizing the employer's ability to meet plan-participation requirements.

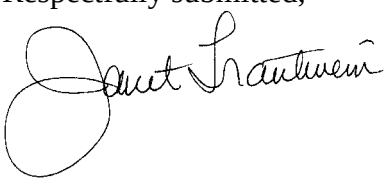
Conclusion

The United States health care system works for the vast majority of its citizens, yet we can do better. Improvement will require strong leadership, a thorough debate of all proposals and, ultimately, difficult compromises and decisions. All stakeholders will feel some pain in order to achieve a universal gain. NAHU agrees with those who recognize that the status quo can no longer be everyone's second choice, and we pledge full participation in the coming debate.

Ultimately, we believe the time is right for a solution that controls medical care spending and guarantees access to affordable coverage for all Americans. We believe this can be accomplished without limiting people's ability to choose the health plan that best fits their needs and without creating an expensive, unneeded new government bureaucracy. We look forward to working with all interested parties in achieving our common goal: a world-class and affordable health care system for all Americans.

I would be happy to respond to any questions or comments. For follow-up after today's hearing, please contact me at (703) 276-3800 or jtrautwein@nahu.org.

Respectfully submitted,



Janet Trautwein
Executive Vice President and CEO